Form 2046 R4.0: Fungal Infection Pre-Infusion Data
Center: CRID:

### Key Fields
- Sequence Number: _______________________
- Date Received: __ __ __ __ - __ __- __ __
- CIBMTR Center Number: _______________________
- CIBMTR Research ID: _______________________
- Event date: _______________________

### Infection Episode
Questions: 1 - 24

Information for this report should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HCT / pre-infusion, or abstraction of the recipient’s medical records.

1 Date of infection diagnosis: __ __ __ __ - __ __- __ __

Specify all diagnostic tests performed, which had a positive result, to determine the diagnosis of the fungal infection.

2 Radiographic findings (e.g. x-ray, CT, or MRI)
- Yes □ No □ Unknown □

3 Specify imaging sites that supported the diagnosis of fungal infection (check all that apply)
- Abdomen / pelvis
- Bone
- Brain
- Chest
- Sinus
- Other imaging site

4 Specify other imaging site: _______________________

5 Pathology (e.g. biopsy, cytology)
- Yes □ No □ Unknown □

6 Specify sample source that supported the diagnosis of fungal infection (check all that apply)
- Brain / central nervous system (CNS)
- Eye
- Liver
- Lung (includes sputum)
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Skin
- Spleen
- Other sample source

7 Specify other sample source: _______________________

8 Culture
- Yes □ No □ Unknown □

9 Specify sample source that supported the diagnosis of fungal infection (check all that apply)
- Blood (includes whole blood, serum, or plasma)
- Bone
- Brain / central nervous system (CNS)
- Eye
- Liver
- Lung (includes sputum)
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Skin
- Spleen
- Other sample source

10 Specify other sample source: _______________________

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Mail, fax or email this form to Minneapolis. Fax: 612-527-5895. Email: scanform@nmdp.org. Retain the original form at the transplant center.

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**Center:**

**CRID:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 KOH / Calcofluor / Giemsa stain</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>12 Specify sample source that supported the diagnosis of fungal infection (check all that apply)</td>
<td>Bone</td>
<td>Bone (including sputum, e.g. esophagus, stomach)</td>
</tr>
<tr>
<td>13 Specify other sample source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Galactomannan assay</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>15 Specify sample source that supported the diagnosis of fungal infection (check all that apply)</td>
<td>Blood</td>
<td>Blood (including whole blood, serum, or plasma)</td>
</tr>
<tr>
<td></td>
<td>Bronchial fluid (BAL)</td>
<td>Bronchial fluid (BAL) (includes sputum)</td>
</tr>
<tr>
<td></td>
<td>Cerebrospinal fluid (CSF)</td>
<td>Cerebrospinal fluid (CSF)</td>
</tr>
<tr>
<td></td>
<td>Other sample source</td>
<td>Other sample source</td>
</tr>
<tr>
<td>16 Specify other sample source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 1,3-Beta-D-glucan (Fungitell) assay</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>18 Specify sample source that supported the diagnosis of fungal infection (check all that apply)</td>
<td>Blood</td>
<td>Blood (including whole blood, serum, or plasma)</td>
</tr>
<tr>
<td></td>
<td>Bronchial fluid (BAL)</td>
<td>Bronchial fluid (BAL) (includes sputum)</td>
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<tr>
<td></td>
<td>Cerebrospinal fluid (CSF)</td>
<td>Cerebrospinal fluid (CSF)</td>
</tr>
<tr>
<td></td>
<td>Other sample source</td>
<td>Other sample source</td>
</tr>
<tr>
<td>19 Specify other sample source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 PCR assay</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>21 Specify sample source that supported the diagnosis of fungal infection (check all that apply)</td>
<td>Blood</td>
<td>Blood (including whole blood, serum, or plasma)</td>
</tr>
<tr>
<td></td>
<td>Bronchial fluid (BAL)</td>
<td>Bronchial fluid (BAL) (includes sputum)</td>
</tr>
<tr>
<td></td>
<td>Cerebrospinal fluid (CSF)</td>
<td>Cerebrospinal fluid (CSF)</td>
</tr>
<tr>
<td></td>
<td>Tissue</td>
<td>Tissue</td>
</tr>
<tr>
<td></td>
<td>Other sample source</td>
<td>Other sample source</td>
</tr>
<tr>
<td>22 Specify other sample source:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Specify tissue (check all that apply)</td>
<td>Brain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upper gastrointestinal (GI) tract</td>
<td>Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)</td>
</tr>
<tr>
<td></td>
<td>Liver</td>
<td>Liver</td>
</tr>
<tr>
<td></td>
<td>Lung</td>
<td>Lung</td>
</tr>
<tr>
<td></td>
<td>Skin</td>
<td>Skin</td>
</tr>
<tr>
<td></td>
<td>Other tissue</td>
<td>Other tissue</td>
</tr>
<tr>
<td>24 Specify other tissue:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Treatment of Infection**

Questions: 25 - 30
**Form 2046 R4.0: Fungal Infection Pre-Infusion Data**

Center: CRID:  

Specify all medications received by the recipient from 7 days prior to the date of infection diagnosis until the end of the reporting period for this form. If the recipient received the medication, please record the date that the medication started.

25 Did the recipient receive any therapy between 7 days prior to the date of infection diagnosis and the date of contact for this reporting period?  
- [ ] yes  
- [ ] no

<table>
<thead>
<tr>
<th>Antifungal Drugs (1)</th>
<th>Questions: 26 - 29</th>
</tr>
</thead>
</table>

26 Antifungal drugs  
- [ ] Amphotericin products (Amphocin, Fungizone, Ambisome, Abelcet, Amphotec)  
- [ ] Anidulafungin (Eraxis)  
- [ ] Caspofungin (Cancidas)  
- [ ] Fluconazole (Diflucan)  
- [ ] Isavuconazole (Cresemba)  
- [ ] Itraconazole (Sporanox)  
- [ ] Micafungin (Mycamine)  
- [ ] Posaconazole (Noxafil)  
- [ ] Voriconazole (Vfend)  
- [ ] Other antifungal drug

27 Specify other antifungal drug:

28 Date therapy started  
- [ ] Known  
- [ ] Unknown

29 Date started: __ __ __ - __ __ - __ __ Date estimated

30 What was the status of the infection? (at the last evaluation prior to the start of the preparative regimen)  
- [ ] Ongoing  
- [ ] Improved  
- [ ] Resolved  
- [ ] Unknown

First Name: ____________________________  
Last Name: ____________________________  
E-mail address: ____________________________  
Date: __ __ __ - __ __ - __ __